

**Meaningful Use Workgroup
Subgroup #2 – Engage Patients and Families
Draft Transcript
June 27, 2012**

Presentation

Operator

All lines are bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good morning everybody, this is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup, subgroup #2, Engaging Patients and Families in Their Care. This is a public call and there will be time for public comment at the end. The call is also being transcribed, so please make sure you identify yourself before speaking. I'll now take roll. Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families – Vice President

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks. Charlene Underwood? Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Leslie. Neil Calman?

Neil Calman – The Institute for Family Health – President and Co-founder

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Neil. Paul Tang? Are there any workgroup members on the line? And are any staff members on the line?

Michelle Nelson - Office of the National Coordinator

Michelle Nelson, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks Michelle.

Josh Seidman – Office of the National Coordinator

Josh Seidman, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks Josh.

Christine Bechtel – National Partnership for Women & Families – Vice President

And MacKenzie, I have Eva Powell from Care Coordination also here.

MacKenzie Robertson – Office of the National Coordinator

Okay.

Emma Potter - Office of the National Coordinator

And Emma Potter, ONC.

MacKenzie Robertson – Office of the National Coordinator

Christine, I'll turn it over to you.

Christine Bechtel – National Partnership for Women & Families – Vice President

Great. Well thanks for joining us again. We've got another ninety minute call scheduled for today to go through and continue to refine and finalize the objectives and criteria for Stage 3. Tomorrow is the full Meaningful Use Workgroup call where some of the groups will presents their work to date, I think Care Coordination is on tap to do that, and I suggested that we present some of the pieces that we think are hand-offs to other groups. And then the next call that we have scheduled is July 20th. So...

Michelle Nelson - Office of the National Coordinator

Christine, I just...tomorrow's call we're going to finish up with subgroup 1 and just talk about your hand-off items and then do the advance directive planning.

Christine Bechtel – National Partnership for Women & Families – Vice President

Oh, okay, that was a little different than the email I got from Paul. So, okay fine. So anyway, so for our call today, what I would like to propose that we do is focus on going back through the table, which is the document, the Conceptual Framework document that starts with our principles and refine them, make some of them more actionable. And as we're going through to sort of refine them, also begin to apply the principles around parsimony that we developed on the last call, and make sure that everything in here should be in here and if not, that it should come out. The other thing that I think we need to do is go through the table that I sent as well separately, and that document is titled MU Subgroup Referrals to other groups and that is where, I think we have some handoffs to make that the criteria belong in other subgroups. So, if that sounds like a good plan to folks, then perhaps what we can do it, I'll just start by quickly going over the table for referrals to other subgroups so you all know what's in there and know that we're not losing anything. And then turn to the conceptual framework document. So, does that make sense to folks? Any questions, any suggestions on the agenda? Okay, great.

So, turning to the document that is a table that we want to refer to other groups; what I did and how I created this table was, I went back and looked at the original Stage 1 and Stage 2 matrices and identified anything that was an adaptation or an addition related to other criteria that belonged in other policy priorities, and then put them in this table with our notes. So the first three are ones that are found under the quality, safety, efficiency and reducing disparities subgroup. And the first is around advanced directives. And so this is a criteria that we've already talked about around the capability to document the POLST and providing patients with the ability to document their advance directive online. So, I'm suggesting we refer that to the quality group, although, and Neil, I think you're on that group; although you know we have also an advance directive hearing planned as well. So, any discussion to that.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I don't know that it belongs...why would be put it in quality?

Christine Bechtel – National Partnership for Women & Families – Vice President

Because that's where it lives currently, under Stage 1, that's the policy priority under which it lives.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay. And then when is the hearing?

Christine Bechtel – National Partnership for Women & Families – Vice President

ONC?

Michelle Nelson - Office of the National Coordinator

It's not scheduled yet, so that's...during tomorrow's workgroup call, that's going to be one of the agenda items, to start planning, have a conversation with the workgroup and kind of talk about what that looks like. We're hoping to do it at the beginning of September, but we don't have a date yet.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I would definitely like to be included in that.

Michelle Nelson - Office of the National Coordinator

Yup, tomorrow's workgroup meeting, all workgroup members are invited.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay, thank you.

Michelle Nelson - Office of the National Coordinator

Yup.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay, so the next one is the recording of sexual orientation and gender identity, and that is race/ethnicity, language and gender recording, already lives under that quality/safety priority. So that's there.

Neil Calman –The Institute for Family Health – President and Co-founder

Christine, can I just make a comment?

Christine Bechtel – National Partnership for Women & Families – Vice President

Yup.

Neil Calman –The Institute for Family Health – President and Co-founder

I mean, I know that things are living elsewhere, but if we have some significant concerns about the way their living elsewhere, maybe we shouldn't turf them.

Christine Bechtel – National Partnership for Women & Families – Vice President

That's absolutely fine. So, if you guys don't want to turf these, then, speak up and we'll move them back into our table.

Neil Calman –The Institute for Family Health – President and Co-founder

Well I think, we've seen in all of our discussions that the issue about gender identity has been thrown first from Stage 1 to Stage 2 to Stage 3, and now possibly out, by virtue of the fact that people are saying that there's no agreed upon coding system, etcetera. And I think that we're basically saying, a number of us have said that that shouldn't obviate a requirement to collect that information and in fact, there are apparently, I've been told by many people since then that there are best practices out there, although they haven't really been adopted as sort of national standards. But then that, and around disabilities, which I think is also critically important. Because if you're really doing something that's patient-and family-centered, and you don't have that information, I think...I know it's not exactly down the main road that you're work has been, but, I think it's important.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay. So I will move that back into this group's...

Michelle Nelson - Office of the National Coordinator

Christine, I will say though that subgroup #1 has talked about this and they are...so there's a number of items that they're looking at that they're deferring to standards, to just see what standards exist today, and so that's where they're at with this item. So, it is a discussion within subgroup #1 as well. Just to kind of...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And if it is given to the patient engagement subteam on standards, I can take that mantle up.

Michelle Nelson - Office of the National Coordinator

Although we're still figuring out how that process works, we have a call on Friday to figure that out, so...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And in that, does that also include Michelle, the demographics question?

Michelle Nelson - Office of the National Coordinator

Yes.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So the patient race/ethnicity and so forth is under there, too?

Michelle Nelson - Office of the National Coordinator

Yup.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay. Sorry, I see that now. Thank you.

Neil Calman –The Institute for Family Health – President and Co-founder

And the disabilities question is huge in relationship to people being able to access their own information, and understand it and whatever. I think that that's...I just want to make sure that it's covered.

Christine Bechtel – National Partnership for Women & Families – Vice President

Yeah, absolutely. So what I've done is two things, one is, that was a good catch Neil, and we talked about it before to add disability status, so I've added that here. So it's now three things, disability status, SOGI and more granular race/ethnicity and language data. And then I've also...I've got it in both, the referrals out and in our group so that we can coordinate with others. Okay?

Neil Calman –The Institute for Family Health – President and Co-founder

Sounds good.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay. The next one is patient decision aids for preference sensitive care. On the last call, we agreed to move that into the clinical decision support intervention category. So this is about alerting providers to high value, preference sensitive conditions using probably some kind of a fixed list from FIMDM, the Foundation for Informed Decision Making. So that is something clinical decision support has lived under quality, safety and not patient engagement, so that's what I've got. Everybody okay with that?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

As long as it stays on the agenda, I'm okay with that. Because it's not generally thought of when people think of clinical decision support; shared decision making is generally separate; but as long as it stays on that agenda, I'm okay with it, because it's a really great opportunity for collaborative care and shared decision making, to use an existing structure inside the EHR, like the CPOEs being used for clinical decisioning. So, I just want to make sure it stays there.

Eva Powell – National Partnership for Women & Families

Well, and this is Eva. As I've gone through the grid for the care coordination and for patient engagement, and I've participated on some of the quality discussions, it occurs to me that there's a lot of collapsing going on, which I think is ultimately a good thing. And particularly when it comes to the fact that there are patient...really there are patient engagement criteria in just about every category at this point, which I think is really a sign that we're moving toward patient-centered care, and that's appropriate. So, I guess instead of trying to own everything under patient engagement, and therefore parsing all of that out completely perhaps to talk about that, as this committee, to talk about it as, "this is something we feel is critically important in our structure that we've been working with for a few stages, this fits better under X category though," and ensure that the discussion that we'll have in future really cover that. Because I think that's potentially a more strategic way to go about it, because then you're not making everything patient engagement, you're making lots of patient engagement stuff, clinical decision support or something that as Leslie states, it sits in the paradigm that people are used to thinking. And that may be a more effective strategy for getting this in.

Christine Bechtel – National Partnership for Women & Families – Vice President

And the purpose of the table that I've created, that you guys have, is to keep it on our radar, so we can refer this to other groups and we will go back and check and see how they're handling it. And then be able to come together as a workgroup and say, no, no, no, here's how we think it should proceed, or how come this didn't make your list, okay fine, well let's...those kinds of things. So, we will keep these on our radar.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

That's great. And maybe what we can do is actually ask for quarterly opportunity to have a specific patient engagement report from every sub-team, as part of both the Policy Committee and the Standards Committee report. Because it is getting to be pervasive, and that is the good news, but let's build some structure around a thematic approach across all of the teams that are doing work.

Christine Bechtel – National Partnership for Women & Families – Vice President

I think these subgroups are time-limited and shortly we will come back together as a full meaningful use workgroup and that's where we'll be able to keep our eye on and continue to raise these issues across the policy priorities. So I think that's a good idea, but I think in spirit we can get there this way.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Oh, good news. Great, thank you.

Christine Bechtel – National Partnership for Women & Families – Vice President

So the next is what I think goes to probably the quality measures workgroup and that was, we had some pieces around patient reported quality measures on functional status measure, not just a functional status reporting. That we still have in our framework, but the functional status measure and patient experience measure. And some issues that we raised around, how do you have a questionnaire that collects standardized data elements that are integrated back into the EHR, etcetera. So, I'm suggesting that probably goes to quality measures, for now, and that's actually where it started, too. So, everybody okay with that?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Well, it does limit the idea of a questionnaire only being used for patient reported measures, where in fact, you can get a lot more information. So...

Christine Bechtel – National Partnership for Women & Families – Vice President

Leslie, I totally know where you're going, but let's come back to this because I think when we get to the view, download, transmit and report piece of our framework...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay.

Christine Bechtel – National Partnership for Women & Families – Vice President

...there's no way you can't do what we're suggesting over there, which has to do with allowing patients to self-report functional status and other things, without that capacity.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay, I'll be quiet.

Christine Bechtel – National Partnership for Women & Families – Vice President

No, that's...no, I'm just saying, I've worked with these documents more, so that's why I know what's in there. So, just bear with us.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

All right.

Christine Bechtel – National Partnership for Women & Families – Vice President

The next is record caregiver status and role. I think this one was a little more tricky for me, because I think the question is whether we're talking about the provider recording the caregiver status and role or the patient self-reporting it. So, that is something that I have in two places; one is to ask the care coordination workgroup to look at it, if they haven't already; and that's using the DECAF structured approach for documenting the role of family caregivers. But I also still have it in the view, download and report function as well; because it's a patient doing that, then that's where it would belong. So, it's sort of in both places so we cover the bases. Everybody okay with that?

W

Yup.

Eva Powell – National Partnership for Women & Families

And we have talked about that on care coordination.

Christine Bechtel – National Partnership for Women & Families – Vice President

The next is CC me or my designees with care summaries or any or all part of my record. So I think that goes to care coordination because it's an action by the provider, and I think they've actually been talking about it. Eva's saying yes. So, are folks comfortable with that, again knowing that we'll make sure it stays on the radar here.

W

Yup.

Christine Bechtel – National Partnership for Women & Families – Vice President

And if not, we should find out...we should be able to find out tomorrow, and we'll put it back on ours. The care plan one is the next one, again under care coordination. But, I think here again, we discussed two different pieces that I think may have come together and actually be the same one. One is this more comprehensive care plan versioning and interoperability, the ability to upload to the EHR and update it with a lead provider designated. But the other is the notion of the whiteboard, the care team and patient whiteboard, and I don't know if those are the same or not. So the whiteboard is still in our conceptual framework, but I have the care plan here. What do folks think?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I think both should be discussed because the whiteboard can be communication only; the framework that we heard, you could have people just using it as a communication platform, but not necessarily updating a care plan. So, I think it's a both and...

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay. And care plan has historically gone under coordination, so, we'll make sure they address that. The next is list of care team members and their roles. And again, this is something that I don't know, so it's currently in both places. It's both under view, download, transmit and report, if it's patient reported data. But it's also under care coordination if it's providers documenting that, because that's where that lives today. There is a care team member documentation requirement in Stage 2 proposed. So, we have it kind of in both places.

Michelle Nelson - Office of the National Coordinator

And the care coordination team talked a lot about this yesterday too.

Eva Powell – National Partnership for Women & Families

Yes.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay, great. All right, and then finally, for care coordination is information sharing preferences. So this is standardized collection of preferences like communication preferences, but this is related to which members of the care team should always be send certain types of information. I don't know if that's something the care coordination group has worked on, but that's one of the things that we're suggesting that they look at, and if not, it could come back to us. Thoughts on that? Or should it belong back in ours?

Neil Calman –The Institute for Family Health – President and Co-founder

I think it fits with the other stuff that you're turning to them.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay. All right, and then the last two are actually two issues for the Privacy and Security Tiger Team, so one is patient-facing systems having the ability to support mobile devices and the second is online secure registration for electronic access, without it having be in person. And Neil, this is the issue you raised last time around the ability to create an account and fill out forms online first, but, to be authenticated on site before accessing the PHI online later. And I think Leslie raised the question of whether there is a need for a national framework for authentication, so we're asking the Privacy and Security Tiger Team to first advise on that and then we can put whatever their outcome is in our part of the framework. Does that make sense to folks?

W

Yes.

Neil Calman –The Institute for Family Health – President and Co-founder

Yes.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay. And then I had two open issues that I wasn't sure what to do with. One was we had something about data feed from PBM. So, I don't know if that's something we want to ask another group to deal with, maybe it's the quality safety group?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

You know, I, yeah, I think it's under quality for medication reconciliation. I think there's one other and that was the API, a patient-facing API, that's sort of the same kind of question. Although the EHR is not the place that generates the PBM information, for medication reconciliation the ability to accept PBM information is huge. And so, that would, I think, is a good concept and possibly does fit under quality and safety.

W

I don't think we should let that go.

Michelle Nelson - Office of the National Coordinator

...med reconciliation? Sorry, if we're talking med reconciliation, that's more care coordination, but if we're talking ePrescribing and formulary checking, that's more quality. At least right now.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

It's actually accepting the PBM information, so it would be more under the quality and safety issues, and reconciliation isn't...it's probably worth a discussion, it's sort of between both of them.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay, so I'm going to put it under the quality piece for now. The patient-facing API Leslie, is that a policy issue or a standards issue?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Well, it's saying, often times we hear the objection that this is not what an EHR is meant to do, right, it's too difficult to do all of these things. Well, one response is to say that if there is a patient-facing API, or an EHR is required to interface with a standard based API; then other systems can actually access information to provide new functionality for patients. So, it really is...I think the policy question is, do we want EHRs to provide open API access for patient engagement systems or patient-facing systems and/or patient quality systems. That's a policy question. Then handing it over to the Standards Committee to say, hey, how would you do this? And maybe the policy isn't even mentioning API, it would just say, a standards-based, patient-facing system collection mechanism, data collection mechanism.

Christine Bechtel – National Partnership for Women & Families – Vice President

Is there a piece of data or pieces of data that we could have collected that would then trigger a requirement for some kind of a standards-based system or API?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Well, it could be a summary of care document as kind of a first phase, it would a summary of care document. Then it would be labs, meds, patient demographics.

Christine Bechtel – National Partnership for Women & Families – Vice President

So we do have those things...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yup.

Christine Bechtel – National Partnership for Women & Families – Vice President

So, do we need to...I mean, right, because the policy requirements have been more around the actions that a provider or a patient should take. So, if we have those things, then would that already kind of trigger...maybe...I'll tell you what, when we get to view, download and report, let's raise this issue again, does that make sense?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yup.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay, so the last open issue that we had is create the capacity for provider to provider consults. Is that something that we want to ask the care coordination group to discuss, if they haven't already, or, that's all I had in my notes, that capacity for provider to provider consults.

Neil Calman –The Institute for Family Health – President and Co-founder

Isn't that direct?

Christine Bechtel – National Partnership for Women & Families – Vice President

(indiscernible).

Neil Calman –The Institute for Family Health – President and Co-founder

Isn't that what direct exchange is?

Christine Bechtel – National Partnership for Women & Families – Vice President

Yeah, I mean my sense was, and the reason I left it in the open issue category was because if you have the purpose really being...if you have requirements around referrals, and care summary transmissions, then it might, in effect, drive that capacity that could also be used for consults.

Neil Calman –The Institute for Family Health – President and Co-founder

Right.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah.

Neil Calman –The Institute for Family Health – President and Co-founder

I would think those are pretty much going to be almost the same application.

Christine Bechtel – National Partnership for Women & Families – Vice President

All right, great. So that takes care of that. So, I've made those edits as we've gone through. So let's turn to the other larger document here, of which the first two pages are the summary definition of patient-centered care and a set of key principles that we used to create the table below. So, given that, what we want to do at this point, hopefully everybody can have in front of them that principles, you know kind of approach that we may want to use for creating some parsimony. I think we need to do two things; one is we sort of need a verb in front of...about every criteria here. So, for example, the first piece is about patient-specific education materials and the verb that should be there, because it's what's already there is "provide" patient-specific education materials. We don't need to get into thresholds and all of that stuff, but we need to have kind of a very associated and we need to do any refining that needs to be done, assuming the objective stays. Okay, is everybody clear on that.

W

Yup.

Christine Bechtel – National Partnership for Women & Families – Vice President

All right. So the first one is provide patient-specific education materials and reminders in the top ten primary languages for the top 100 diagnoses, treatments and tests. So this is, in terms of our principles here, this is an adaptation to a measure, so we don't need to think about whether that's topped out, because this is different and it's not being done. I think it does enable, or support, accelerate delivery system change, I think it is helpful in that matter, although not quite as directly as some other ones. Is it fed by the EHR? I think yes, right?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Absolutely. It's in the context, it's in the actual info button standard.

Christine Bechtel – National Partnership for Women & Families – Vice President

Is it outcomes oriented, improves efficiency for patients or providers?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Absolutely. When 40% of the patient readmissions are caused because the patient does not understand how to do self-care or understand how their...

Christine Bechtel – National Partnership for Women & Families – Vice President

And it's not already driven by market forces, we know that, because it's not really happening. Is it widely applicable to a broad range of provider types?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Absolutely.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay. Aspirational but achievable? I have a question about that, I want to come back to and clear in its meaning. I think it is clear in its meaning, if you guys agree.

Neil Calman –The Institute for Family Health – President and Co-founder

Is it top 100 of each?

Christine Bechtel – National Partnership for Women & Families – Vice President

This is the aspirational but achievable part. So, it's a top 10 primary languages for the top 100 diagnoses, treatments and tests; which I think actually turns out to be a hugely broad number of things, despite the fact that we're trying to limit it.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I think we should have "or" instead of "and."

Neil Calman –The Institute for Family Health – President and Co-founder

No.

Christine Bechtel – National Partnership for Women & Families – Vice President

Well, I think, let me propose a slightly different way to look at this one, which is, to say we created a capacity in Stage 1 and in Stage 2 for providers to generate a list of patients according to their language designation, right? So could we instead say that really what you need to do is provide education materials and/or reminders or and reminders in the top 2 or 3 primary languages for the patient population?

Neil Calman –The Institute for Family Health – President and Co-founder

I would suggest...I was going to suggest that we use the top 2 or 3, but the top 2 or 3 it varies tremendously. Like, the number 2 could be only 0.1% of patients in a particular setting; it could be 50% of patients in another setting. So, I don't know if we really want to...I think that Office of Civil Rights has some measure for this, that if it's more than a certain percentage of your population, you have to do it. And so it doesn't limit it by the number of languages, it limits it by the prevalence of the language in your population.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So, Joint Commission requires that to...it requires that you can deliver it through an interpreter, right? So, this is basically electronic provision and we'd have to have a national standard that says here are the top three languages. And you'd probably have Spanish no matter what, as one of those. But, otherwise; for instance if you go to Wisconsin, you have a high Hmong population; if you go to Florida, we have a lot of Spanish and many other languages, Haitian. So, it's got to be...in order to actually make it achievable, we either have top 100 diagnoses and two or three languages based upon national prevalence, or you go to much fewer diagnoses based upon regional prevalence.

Neil Calman –The Institute for Family Health – President and Co-founder

So let me just say two things. So, first of all, I think we should...that it shouldn't be based on national data, because the problem is a local problem...

Christine Bechtel – National Partnership for Women & Families – Vice President

I agree.

Neil Calman –The Institute for Family Health – President and Co-founder

...and any healthcare provider practicing in a place where 20% of their population speaks some strange...some unknown nationally sort of rare national dialect of something, needs to provide information in that language. I mean, it's a local issue. Second of all, these...there's commercially available...this stuff is commercially available, it's also available through the National Library of Medicine in, I forget how many languages, 14 languages already. You can pretty much get all of the information on every possible pharmaceutical, most lab tests, in many languages, and it's available free of charge through that portal...through a portal that they have. And we're interfaced with that, so literally this is not like rocket science. It's already available, we're just basically calling out the need for people to couple with it and provide it. I would say that any population that represents, just to put something out there, for any population that represents more than 5% of a provider's patient population. Because I think that would keep it local and keep it locally based.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And it would cover a lot more than...so you just still say two or three top languages for that.

Neil Calman –The Institute for Family Health – President and Co-founder

Well, it could be, for some providers, it might be five or six that are above 5% of their population.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So just to... we've been doing it for about thirty-five years, and the tests are one thing, the drugs are another thing. The diagnosis and treatment across all of those is a much broader category. So, it's very...what we don't want to have happen is the provision of languages reduce the number of overall materials that are available. So, I mean we produce things in languages, a narrow scope, to address what's actually prevalent in care. So, I think there are ways to word this so that we get to local without making or reducing the overall scope of available languages.

Christine Bechtel – National Partnership for Women & Families – Vice President

So what I have is generate list of patients by preferred language and provide patient-specific education materials and/or reminders in languages spoken by more than 5% of patient population. Is that right? I mean, we don't have to...and I'll stop and ask the ONC staff to confirm this. I don't think we have to figure out sort of like the...because one way to handle the issue you're describing Leslie is through thresholds. So we could say that if...I think Stage 1 and 2 are, you've got to provide education materials to 10% of your patient population.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right.

Christine Bechtel – National Partnership for Women & Families – Vice President

So one way to do that would be to say, of that 10%, 1% should be in whatever, you know, because if we just create the capacity and the workflow change, they'll continue to do it if it's helpful.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right.

Christine Bechtel – National Partnership for Women & Families – Vice President

But it may be that that's not quite enough. So, if we're at a point where we can get the concept down and request feedback from either other...either from the Policy Committee or from the public around how to structure this to make it meaningful, but achievable, then maybe we stop short of trying to work out every detail here. ONC, can you guys confirm sort of that my thinking is right on that, that there's going to be more opportunities to get ideas from other organizations and stakeholders?

Josh Seidman – Office of the National Coordinator

This is Josh, and I guess what I would say is, what you can do is you can sort of talk about the possibility...when the Policy Committee puts out the request for comment this fall, you could put out possibilities as considering and ask specific questions and for input around how to structure it.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay. Right.

Josh Seidman – Office of the National Coordinator

And to the extent that any of these things would require any kinds of standards or certification criteria, those would be things to bring to the Standards Committee at that time as well.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay.

Christine Bechtel – National Partnership for Women & Families – Vice President

All right, so are folks okay with that approach?

Neil Calman –The Institute for Family Health – President and Co-founder

Yes.

Christine Bechtel – National Partnership for Women & Families – Vice President

All right. So the next one...by the way, so we just went through the principles for parsimony. I don't want to go through them one by one on everything out loud, I just wanted to do that as a nice exercise. I think given the fact that a number of these are adaptations, they already meet many of these principles. I think what I'll do, unless you guys disagree, is to just allow us to sort of stop and if everybody's got the principles in front of them, we can look at them and give our sense of how well the criteria matches these principles; rather than go through each one, unless you all want to. Sound good?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay, we'll try it. All right. So the next one is the piece that we moved back in is around recording disability status, sexual orientation and gender identity and more granular race/ethnicity and language data. I think that to me, has been something that's worthy of continuing to include. We've been, as Neil pointed out earlier, it was in several stages and has been a moving target, but I think it's there enough to get some feedback on. Do you guys agree?

Neil Calman –The Institute for Family Health – President and Co-founder

I do.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah.

Christine Bechtel – National Partnership for Women & Families – Vice President

Good. So, care coordination or I mean, under this kind of domain, the next one is, “Identify patient-specific opportunities for enrollment in research and clinical trials.” So if we think about our parsimony principles, it’s new, so it’s not topped out. I think it definitely could be fed by or feed into the EHR outcomes oriented and definitely actionable, not driven by market forces already. I think the question is, is it achievable. So we had a lot of questions in the notes around patients who want to identify themselves for enrollment opportunities, but you can do that, you can flag those patients in the EHR, but how do we then make it actionable, how do we connect them to the research community. So, this is one that, as much as I like the idea, I’m not sure we’re ready to get here.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I was just at a conference on electronic data methods with AHIMA over the weekend and they talked about this as a big problem in two ways. One is that by not having a way to identify patients who want to participate, then we could overburden the physician, the clinician by asking many more questions at the point of care, not necessarily materials to the episode of care, but material to the research collection. And so, is there a balance between, hey this is a patient I’d like to be considered, there is an opportunity for enrollment and that patient now can get questionnaires online, can be asked questions in a different way, and not burden the clinician at the point of care, because they’re trying to gather the needed information for research. I don’t know, Neil, you’re more close to this than any of us, what do you think?

Neil Calman –The Institute for Family Health – President and Co-founder

Well, I’m just looking...I’m looking at the...like right now at the clinical trials.gov website and I’m just thinking, like what we’re really talking about is a way of connecting people...it looks to me...given that basically you can do a search on any diagnosis and geographic location, it seems to me like it would be pretty easy to figure out a way to link that electronically into an electronic health record, so that somebody...it doesn’t show up all the time, but with the click of a button, somebody could like a patient’s diagnosis with their location and bring up a list of clinical trials. I mean, I just ran two or three of these and, it’s always staggering when you do this.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Actually, you’re quite right Neil. The same standard that you’re using to connect to the NLM or that people use to connect to...the HL7 contextual query or the info button standard could be used to identify patient-specific opportunities quite easily.

Neil Calman –The Institute for Family Health – President and Co-founder

I mean, the results are quite amazing and this could easily be put into an electronic health record to do this. So somebody could say, well are there any clinical trials on diabetes going on in New York, and just linking diabetes in New York, you end up with a list of a few hundred things which you could just print for the patient, or you could go over with them, or whatever. So, and it lists them as whether they’re actively recruiting or not, so...you know, I...

Christine Bechtel – National Partnership for Women & Families – Vice President

But Neil, do you...does that require or is it accelerated by some role that the EHR plays as opposed to you just going into the separate database?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

It does because the term patient-specific is half of the context, so I now know the chief complaint, the principle diagnosis, the age, the gender and the lab results, the language of the patient, all that context is passed. So, it actually would accelerate identifying patients at the point of care, very easily.

Eva Powell – National Partnership for Women & Families

Could this somehow be automated through CDS?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yes, it can. It would be using the same standard and it would be very, you know a minimal amount of work to do this, with a huge outcome for the research community and support from AHIMA.

Eva Powell – National Partnership for Women & Families

And I know, AcademyHealth, just as a side note, is doing a lot of work on involving patients more closely in research, and so, they might be a resource if we need to tap into them.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yup, that's where I was this week.

Neil Calman –The Institute for Family Health – President and Co-founder

Yeah. It's not something that patients think about, I mean I can't remember the last time anybody came into my office and asked if there was a clinical trial about something.. But, it could be a major contribution. I think it's worth keeping on the list, you know, all this stuff is going to go through a process, but I don't think we should edit it out.

W

Well and it strikes me too that this can be, I mean there may be people who come in and ask for a clinical trial, but like Neil, I think that this is almost always, or at least most often, going to be a conversation that's introduced by the physician, which, in my view, is an open door to shared decision-making, or the first step in that process.

W

I agree.

Christine Bechtel – National Partnership for Women & Families – Vice President

All right, great. All right, I think I've got it. So, the next one is our kind of big bucket item, which is view, download, transmit and what we now also refer to "and report." So this is the inclusion of the ability to upload or report data into the primary place of choosing by the patient. So, we have two kind of categories of things here. One is, patient-reported data that is available to the patient and the provider, and there's a list of it in the table that you see: family health history, patient-created health goals, observations of daily living, caregiver status and role, list of care team members, functional status and self-reporting of adherence to medications, diet, exercise regimen or care plan. My sense is that the verb that's needed here is essentially to provide patients with the opportunity to self-input relevant health data, which could be any of those that I just listed. Does that sound right to folks?

W

Yup.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay. And then we also have this sort of big list of functionality, and I struggled a little bit more with this because I think some of them are things that the market probably should be relied on to do, but I also think that we have to figure out a way for...we haven't really, I think, dictated necessarily a functionality creation, so if you think about the ability to chart your progress and trending over time, which EHRs have the capability to do today, you can look at my weight over the five year period and see what's happened, for example. But we didn't mandate that ability to display that graphic in meaningful use, right. So, we have to kind of figure out how to handle some of these. So I think what we should do is go through them one by one.

So the first is actually patient-specific education materials and linkages to online resources. And this is different from the first one we discussed, this is about making sure that the portal is linking to online resources to help patients interpret the information in the record and improve their knowledge of conditions and treatments, etcetera. And we talked about the fact that education materials could be delivered through the portal, secure message, etcetera. I think the education materials themselves are already part of meaningful use in a way, but what this is trying to say is that within the portal, do we want to try to somehow require the information contains linkages in there, or is that getting too deep into workflow or functionality.

Neil Calman –The Institute for Family Health – President and Co-founder

Well I think this is a red...I mean, I'm biased here, so I'll state this right up front, but I think since this is so readily available, it would be a crime not to call it out. I mean...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I'm with you there because, the other argument that we have here all the time about patient's access to information, is that they can't possibly understand it. Just eliminate that objection.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay. Okay, great. All right. So the next is "track monitor or chart progress against patient care goals." So what's the verb there and is it something that should stay?

Neil Calman –The Institute for Family Health – President and Co-founder

I think this one...I found this very nebulous. I wouldn't...I think it's got to be much more specific if we're going to make anything meaningful out of it.

Christine Bechtel – National Partnership for Women & Families – Vice President

Right.

Neil Calman –The Institute for Family Health – President and Cofounder

Because, I mean if your goal is to lose weight, that's easy to be able to track or monitor quantitatively. If your goal is supposed to be, to be happier and to exercise more, like how do you monitor that? Or to spend more time with family? I mean, I just don't think it's all conducive to being able to tracked and monitored in the same way.

Christine Bechtel – National Partnership for Women & Families – Vice President

Yeah, it's Christine, I don't disagree, I think when we look at the principles it's not totally clear in its meaning for the reasons you just said and, probably not applicable to a broad range of providers, because if we think about this online access functionality being applicable to specialists too, I'm not sure how much that's going to function in there. So, Leslie, what do you think, should we remove it or adapt it?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

It's just, I think it's a point to write on. I think we need to...do we have it someplace else, because the patient can report back on their status of their...I don't even know if it's the care goals, as Neil said,

because care goals are more around the care plan and the coordination of care group. This is if the doctor said to you, how are you doing on your weight, I want to either track it every week or I want your daily blood pressure graft for the month, it's really getting to very specific items to track. Is there a better way to talk about that?

Neil Calman –The Institute for Family Health – President and Co-founder

But we could say limited to quantifiable goals or something like that, if you want to keep it.

Christine Bechtel – National Partnership for Women & Families – Vice President

Well, we do have right above this the self-reporting of adherence to like meds, diet, exercise or care plan; so that might cover the ability to self-report.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

That covers it.

Christine Bechtel – National Partnership for Women & Families – Vice President

All right, that's good, because we do need to simplify it, so that works. The next is "provide patients the ability to send updated information to the care team members across settings and providers." And we, in one of our calls, had a note that said we needed to think through any complexities that could be created by patients sending updates, like what do providers really need to know, what are the operational challenges in doing that. My sense is that what this is trying to do is really just create a technical capacity, but when I look at the above list of what we're saying that patient could have the ability to self-report. We do have in there, health goals, we do have...we can add actually ability to correct errors, you know, information reconciliation and it might cover it, but it's that send updated info to care team across settings that is the real crux of this one.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right.

Neil Calman –The Institute for Family Health – President and Co-founder

I mean, I think maybe we want to differentiate between self-recording and then reporting, which would be...recording would be their ability to enter their daily weight into a log if they wanted to, but it wouldn't automatically get sent to all their providers; and their ability which is called out elsewhere, to be able to send a message to one or more providers. But, I don't think the two of those should be linked because otherwise we're going to end up with craziness.

Christine Bechtel – National Partnership for Women & Families – Vice President

Right. I guess what I was wondering is, I do like the ability of the patient to send updated information to the care team, but I'm wondering if it could be addressed through secure messaging and the download function. Because if I'm able to download my health information and pull it into one place, and we're now actually creating an upload function as well, does that give me the ability to, when I need to, to just bring or send that updated information to my care team. I mean, it may be printing it on paper, but it's that send function that I think is the question here.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah. One of the things in the patient-generated data hearing they talked about was the ability to not only receive information, but for the clinician to say yes, I want to accept that into my EHR or that's just nice to know. So, there was that idea of updating is necessary and sending it to a care team is necessary that the functionality in the EHR for the doctor to accept it was in an important sort of yin and yang to that.

Neil Calman –The Institute for Family Health – President and Co-founder

Yeah, this gets really, really complex, because if people are entering information and I'm not looking at it, am I responsible for knowing it?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And the AMA part of the quote that was in the white paper said that the clinician has the responsibility to decide whether to act on it or not or whether it needs to be included in the EHR and their only responsible for those things that they include as part of the care record.

Neil Calman –The Institute for Family Health – President and Co-founder

Yeah but...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So accepting it was a concept they wanted to make sure, so they didn't get...

Neil Calman –The Institute for Family Health – President and Co-founder

Yeah, but I don't know how to...

Christine Bechtel – National Partnership for Women & Families – Vice President

Well, is it something that would become a natural byproduct of creating the capacity for patients to self-report a wide range of data?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Maybe.

Christine Bechtel – National Partnership for Women & Families – Vice President

I mean, doesn't it have to sort of come with that?

Neil Calman –The Institute for Family Health – President and Co-founder

In other words, I guess what I'm saying is, I would want there to be an explicit function which says, "send this to this provider," as opposed to like every time you enter a weight, it sort of... it automatically kind of updates your record and somehow somebody's supposed to be responsible for looking at that. So I think explicitly separating the recording function from the sending function.

Christine Bechtel – National Partnership for Women & Families – Vice President

It is separated. Right now it just reads, "provide patients the ability to send updated info to care team members."

Neil Calman –The Institute for Family Health – President and Co-founder

I don't see any problem with that. I mean, as long as it's something, you know, it's an explicit act that they have to send it, I guess we'll just have to see what happens. I mean, it's better than saying they can't send it. That's the only other option, right, so, I would say they should be able to send it and we just have to figure out what... people are going to have to learn what's appropriate to send and what's not, just like with messaging.

Christine Bechtel – National Partnership for Women & Families – Vice President

But what I think Leslie is saying is also to add to this and an ability of providers to review, accept and reject updates, right?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yup.

Neil Calman –The Institute for Family Health – President and Co-founder

I don't know how you would reject an update.

Christine Bechtel – National Partnership for Women & Families – Vice President

Well, or only pull pieces in.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Part of it is, Neil, is the versioning thing, right, I don't want four versions of this same thing.

Neil Calman –The Institute for Family Health – President and Co-founder

I know. But if a patient says, you have this all wrong, I really didn't have gallbladder disease, it really turned out to be an ulcer, you know, like how do I not accept that piece of information? I mean, they've sent it to me, it's in the record, it's recorded, it's not erased, it's not expunged from the record just because I don't accept it.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah.

Neil Calman –The Institute for Family Health – President and Co-founder

So it's kind of... I think we're creating some false reassurances here. I mean...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I think what the examples were given in the meeting that they had really high success when it was clear what kind of data was going to be accepted and not; things like, I don't really want your Facebook diary or timeline. I don't want that. But I do want your daily blood pressure. And so, I don't think we have to belabor it here, I think if we... when the standards group starts looking at all this complexity, that that structure will emerge.

Neil Calman –The Institute for Family Health – President and Co-founder

I agree.

Christine Bechtel – National Partnership for Women & Families – Vice President

So leave it in though for now.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay. The next one is pre-visit prep tools; so collecting updated health history, which we kind of have covered above, but ability to consent to treatment, fill out administrative forms. My question here given that we need to get to some parsimony is, is this something that the market should already be addressing?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Well, there's nothing in the market that says somebody has to take it in or accept it; so, even organizations who are doing this really well, like NoMoreClipboard. They would probably send this as a direct message, so the market has the mechanism collection in maybe a direct message, but today there's nothing that says the patient can generate that, a patient is included as a direct participant. So, it's just another type of data, but administrative forms does get to efficiency for the provider.

Christine Bechtel – National Partnership for Women & Families – Vice President

Right, but I think this is about that only the patient can consent to treatment, only they can do the filling out of admin forms. So, for me, this is about whether or not, I assume, that if the clinic decides that they want to have this functionality, they're going to use it because why else would they invest in creating that capacity to do it, when it's the patient doing the ability to...you know, consenting to treatment and filling out the forms.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I don't know because there are tools in the market that allow patients to do this today, but there's nothing that forces that that actually gets accepted into the...back into the record...there's no mechanism for acceptance, accepted into other PHR. So, this gets to being able to accept it from an external source, any patient-facing system or...is the market responding? Yeah, it's responding with the tools, but not necessarily the interoperability. Yes.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay, so what you're saying is create the capacity to accept pre-visit prep tools into the EHR, e.g. the ability to consent to treatment and fill out admin forms.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right.

Christine Bechtel – National Partnership for Women & Families – Vice President

But admin forms don't necessarily go into the EHR right, or the PM systems?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

They can, consent forms generally do go into the EHR.

Christine Bechtel – National Partnership for Women & Families – Vice President

I guess I'm just struggling with this...it's not just I like the convenience, I think the administrative forms and the consent forms, I don't think they feed to or from the EHR.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

They do. You can't do an admit to an OR without administrative data. You can't do...it's the initial intake before you can do anything else.

Christine Bechtel – National Partnership for Women & Families – Vice President

Right. That makes sense. Okay, so leave it in.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yup.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay, the next one is, "receive data from telemedicine and biomedical devices," which seems very broad.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah.

Christine Bechtel – National Partnership for Women & Families – Vice President

And I don't know how to either make it specific, I mean, we need to do this. I don't know, I think the care coordination group is doing some of it, but I'm not sure what they're doing.

Eva Powell – National Partnership for Women & Families

Well, we're definitely talking about receiving like clinical data from the device to the EHR. Now, that's a little different than what, I forget what his name is who was at the hearing, who talked...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Hugo. Hugo Campos.

Christine Bechtel – National Partnership for Women & Families – Vice President

Yeah.

Eva Powell – National Partnership for Women & Families

...yeah, that his device...that he's not able to get information about his own device and so that's a little bit different. But, I don't see that as something that comes from the EHR is even really connected to the physician; that's something that is the device manufacturer's purview.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

But if it's a home scale for CHF or a...you know, more of the home-based devices, I think is what was being discussed here. I'm trying to remember the group that talked about it, but...

Christine Bechtel – National Partnership for Women & Families – Vice President

Well, the way...one way to deal with this would be to create the capacity for the EHR to receive data from biomedical devices and by virtue of that, create the capacity through online access, to display that data to patients.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Oh, that's cool.

Christine Bechtel – National Partnership for Women & Families – Vice President

Right?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah, that's cool.

Christine Bechtel – National Partnership for Women & Families – Vice President

So I think it's still very broad, I don't know exactly what the criteria, you know, how it could be sort of worded, and I don't think you can say, "You will receive data from x-percent of your patients telemedicine devices or something like that," because what if they just don't have any. But what we really do need to do is create that capacity to do it.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah. So, what about...Neil, have you ever sent somebody home with a heart Holter or any kind of device that is uploading to the EHR or needs to?

Neil Calman –The Institute for Family Health – President and Co-founder

No, we don't have anything. Right now we're just in the process of replacing our first machines in-house that are going to interface with the EHR, but we've not done that at all.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah. So, the hospital that I worked for, we got the most information remotely from patients who were in our congestive heart failure patient group, and that was their scales, and that really prevented readmission, really prevented readmission. So, I'm not sure if these needs to be targeted to a particular group of patients or just, I think maybe you're right, Christine, I think it is just creating the capacity.

Christine Bechtel – National Partnership for Women & Families – Vice President

Yeah, I think that's all it is. The next one is information reconciliation, which I think might actually go above in the...I don't know if it's sort of a form of patient-reported data, but we need to create the ability of a patient to correct their record or add addenda, things like that.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yup.

Christine Bechtel – National Partnership for Women & Families – Vice President

And again, I think it's creating the capacity, but I think it's offering it to patients. Okay. All right, and then the last is, again it's sort of another functionality piece that I'm not sure stays in. I mean, I think it's nice, but it's ability to compare self with other patients, see risk status, understand what evidence-based care for the patient's condition is.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I think that might go to the quality group, that's really patient-specific dashboard; how am I doing against national standards and how am I doing against your organization's data.

Christine Bechtel – National Partnership for Women & Families – Vice President

I think that's actually a really good idea.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay. All right, let me just drop this in there and we will keep rolling. Okay. So that takes us through view, download and report. The next is a placeholder around receiving alerts for recalls, for drug recalls or devices. And I think we can skip that for now, because we're really waiting to see what happens in Stage 2 and if the right pieces are in place, we can delete this one. So I suggest we skip for now, and we've got two other ones. So, one is access and update patient whiteboard, which is the collaborative care platform. And I've described it as a central clearinghouse for which care team members will interact with the patient for what purpose, include the ability to track progress against the care plan and for the patient caregiver to input information or give feedback on information that's in there. It's interactive, collaborative, dynamic; it's not just sort of a document.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay, and that's a new piece. The other new piece that we have is...that I think we need some thinking around, is creating the capacity for online visits and consults. So this is again, just to create the capacity in support of future payment models. We can't require it to be used, because, then you get into the uproar around paying for online visits. But, it's just really creating that capacity and making sure that the information from the encounter is digestible by the EHR, make sure it's actionable for clinical and billing purposes, things like that. So, I think that's right.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yes.

Christine Bechtel – National Partnership for Women & Families – Vice President

It's just hard to sort of figure out how you create the capacity. Okay?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah, I think it's an important concept. And then we've got a number of years to get these things nailed, you know.

Christine Bechtel – National Partnership for Women & Families – Vice President

Yes. All right, so that takes us through the table. Is there anything that we just discussed that you guys are like no, this really shouldn't be in here, or it's not right or it needs more or I don't understand it?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I think that you did great.

Neil Calman –The Institute for Family Health – President and Co-founder

And I think it's fine.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay. All right, good. Well, we'll...I think that it does have a fair amount of new stuff under view, download, transmit and report and so I think that may be a little scary for folks and we'll need you to help people understand that context of the conversation that we had today. So, I'll work on cleaning up this table and trying to put it into Michelle's format that she has, that is being used by other groups. We do not have Charlene or Paul on the line today, so, we may need...I may need to reach out to them and get their feedback on the outcome before presenting it to the full workgroup, but, I'll touch base with them and see what they see. Does that make sense?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I did discuss the whiteboard concept, I think both Eva and I did, at the care coordination meeting and, I think there's a lot of complimentary messages between us and the care coordination team.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay, I hope so. So it may be that we can simplify some of this.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yup.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay, great. All right, so I think that's actually all we have on our agenda, Michelle or Josh, unless you guys tell me otherwise. We have our next call on July 20th and I think we need to use that time to go through and look at changes that will need to be made based on the work of other subgroups, and the feedback from the meaningful use workgroup. Any thoughts on that, Michelle, Josh or anybody from ONC?

Michelle Nelson - Office of the National Coordinator

I'm sorry, I'm walking, but, the only thing I'm worried about is I know Paul wants to get to consensus, probably sooner than that, so we'll have to kind of keep that in mind.

Christine Bechtel – National Partnership for Women & Families – Vice President

Okay, well we can work with him on the timeline.

Michelle Nelson - Office of the National Coordinator

Okay.

Christine Bechtel – National Partnership for Women & Families – Vice President

And hopefully Neil and Leslie, you guys are both going to be on the call tomorrow, the meaningful use full workgroup.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah, that's at 7 my time, right? I think.

Christine Bechtel – National Partnership for Women & Families – Vice President

Yeah.

Neil Calman –The Institute for Family Health – President and Co-founder

Yeah, I'm going to be on in the beginning, but I have patients scheduled shortly after that, so...

Christine Bechtel – National Partnership for Women & Families – Vice President

All right, okay fine. So, we'll open the line for public comment.

MacKenzie Robertson – Office of the National Coordinator

Operator, can you please open the lines for public comment.

Public Comment

Alan Merritt – Altarum Institute

If you'd like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1; or if you are listening via your telephone, you may press *1 at this time to be entered into the queue. We have no comments at this time.

Christine Bechtel – National Partnership for Women & Families – Vice President

All right great. Thanks to you guys, the workgroup members, for your hard work today and on past calls, and I'll talk to you guys tomorrow.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

All right, thanks Christine, thanks Neil, thanks Eva.

MacKenzie Robertson – Office of the National Coordinator

Thanks everybody.